IN CONFIDENCE

**IMAGING DEPARTMENT**

###### APPLICATION FOR XRAYS/SCANS UNDER THE

**GENERAL DATA PROTECTION REGULATION (GDPR)**

**\*\* PLEASE NOTE: From 1st June 2025 imaging will no longer be provided on disc and will be sent electronically via the Image Exchange Portal \*\***

**PLEASE COMPLETE IN BLOCK CAPITALS**

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**DETAILS OF THE PERSON WHOSE INFORMATION IS REQUESTED**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Surname: |  | | | Title |  |
| Forename(s) |  | | | | |
| Date of birth: |  | | | | |
| NHS or Hospital number |  | | | | |
| Current address |  | | | | |
|  | | | | |
|  | | | | |
| Country |  | Post Code | | |
| Previous address |  | | | | |
|  | | | | |
|  | | | | |
| Country |  | Post Code | | |
| Telephone No. |  | | | | |
| Mobile No. |  | | | | |
| Email address |  | | | | |
| Alternative Email address  (***please provide this if you do not have a UK mobile number***) |  | | | | |

**PLEASE GIVE DETAILS OF THE EPISODES OF TREATMENT FOR WHICH ACCESS TO INFORMATION IS REQUESTED.**

Please provide as much information as possible. Give full details of all episodes you are interested in and if you only wish to receive data relating to a specific aspect of one or other of these episodes, please specify in the comments section below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Hospital** | **Dates** | **Ward or Outpatient Clinic** | **Consultant** |
| 1. | **…………………………..** | **………………………….** | **…………………………………..** | **……………………………..** |
| 2. | **…………………………..** | **………………………….** | **…………………………………..** | **……………………………..** |
| 3. | **…………………………..** | **………………………….** | **…………………………………..** | **……………………………..** |
| 4. | **…………………………..** | **………………………….** | **…………………………………..** | **……………………………..** |

Other information requested (please give details).................................................................................................................……

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**DECLARATION**

I declare that the information given in this form is correct, to the best of my knowledge and that:

\* I am the person named overleaf.

\* I am acting on behalf of the person named overleaf.

\* I am the guardian of the patient who is a child and (is incapable of understanding the request)

\* I am the deceased patient's personal representative and attach confirmation of my appointment.

\* I have a claim arising from the patient's death and wish to access information relevant to my claim and

attach supporting documentation from the personal representative.

(\*Delete as appropriate)

I understand that under the General Data Protection Regulation (GDPR) there is no charge for my Imaging.

Signature of Applicant:……………………………………………………. Date:………………….……………………..

**NOTE**

a. If you are acting on behalf of another person, Part 1 of the "Authorisation" section below must be completed.

b. In the case of the patient being a child, Part 2 of the "Authorisation" section below must also be completed**.**

Applicants Name............................................................ Address to which a reply should be sent

(**Print in Capitals**) (**if different from that specified on Page 1**)

.........................................................................................

.........................................................................................

………………………………………………………………..

Signature of Applicant.................................................... Date.................................................................

**AUTHORISATION**

Part 1 (on behalf of another person)

I hereby authorise Imperial College Healthcare NHS Trust to release any personal information they may hold relating to

me to:.........................................................................................(**full** **name of the person acting on your** **behalf).**

Signed……........................................................................ Date.................................................

Mobile No:………………………………………….……......… **(of the person acting on your** **behalf)**

Email:………………………………………………………....... **(of the person acting on your** **behalf)**

Alternative Email:………………………..…………………..… **(of the person acting on your** **behalf if they do not have a UK mobile number)**

Current address **(of the person acting on your** **behalf):**

**…………………………………………………………………………………………….……………………………………..……..**

**………………………………………………………………………………………………………………………………………….**

Part 2 (In the case of the patient being a child, a responsible adult should certify where appropriate that the child understands the nature of the application).

I (name)......................................................................................................................

of (address).................................................................................................................................................................

certify that the applicant understands the nature of this application.

Signed................................................................................... Date.........................................................

**IN ORDER THAT WE CAN SAFEGUARD YOUR INFORMATION COULD YOU PLEASE PROVIDE PROOF OF IDENTITY SUCH AS A COPY OF YOUR PASSPORT, DRIVING LICENCE, OR 2 UTILITY BILLS IN THE NAME OF THE APPLICANT DATED WITHIN THE LAST 3 MONTHS**

**PLEASE RETURN THE COMPLETED FORM AND ID TO:**

Patient Data Access Co-ordinator

Department of Imaging

Hammersmith Hospital

Du Cane Road

London

W12 0HS

**Email:** [imperial.imagingcdrequest@nhs.net](mailto:imperial.imagingcdrequest@nhs.net)

**Telephone:** 020 3313 4907